EXHIBIT A DATE:_____

APPLICATION FOR REGISTRATION OF
SELF-FUNDED EMPLOYEE HEALTH CARE PLAN

_____
(Name of Trust Fund)

_____
(Address of Principal Office of Fund) (Phone No.)

Effective date of the Plan:_____

To the Director of Insurance of the State of Idaho:

STATE OF)
COUNTY OF) ss
)

_____, Employer(s) and

_____, Trustee, being duly sworn each for himself deposes and says that the information contained in this Application for Registration is true to the best of his knowledge and belief.

_____
Employer(s)

_____
Trustee

Subscribed and sworn to before me this

_____day of_____. 19__

_____

My Commission Expires:_____

REGISTRATION

GENERAL INTERROGATORIES

1. Is this Plan maintained for the purpose of complying with any workers' compensation law or unemployment compensation disability insurance law?

   _____

2. Is this Plan administered by or for the Federal Government of agency thereof?

---

3. Is this Plan primarily for the purpose of providing first aid care and treatment, at a dispensary of the employer, for injury or sickness of employees while engaged in their employment?_____
   (If yes, describe)

4. Has this Plan been in existence and operation for a period of fifteen (15) years immediately prior to July 1, 1974?_____

   If yes, provide effective date of operation:_____

5. Is this a self-funded plan established for the sole purpose of funding the dollar amount of a deductible clause contained in the provisions of an insurance contract issued by an insurer duly authorized to transact disability insruance in this state? Please provide information as to the number of deductibles per family and deductible amount per person._____

   _____

   Please indicate number of beneficiaries insured and the total aggregate amount of all deductible obligations._____

6. Give the names and addresses of the employer(s) for whose employee-beneficiaries the trust fund is operated._____

   _____

   _____

   _____

   _____

7. Give the name and address of the administrator of the Plan.

_____

_____

_____

8. Give the names and addresses of the trustees of the Plan.

_____

_____

_____

9. Give the names and addresses of Plan consultants, if any.

_____

_____

_____

10. Give the names and addresses of insurance agents or brokers transacting business with the Plan, if any.

_____

_____

_____

11. Give the names and addresses of associated or affiliated trust funds and/or Plans under control of management of the administrator or trustees named herein.

_____

_____

_____

_____

12. If benefits are provided by any means other than direct payments of a trust fund, please complete the following schedule and attach a copy of the group policy and/or other contract covering these benefits:

GENERAL DESCRIPTION OF BENEFIT	NAME & ADDRESS OF PERSON PROVIDING BENEFITS

13. Are all contributions to the Fund payable in advance?

    _____

14. Does the Plan operate under the provisions of a Trust Agreement between the employer(s) and the Trustee?_____

15. Have guidelines been established for trustees and administrators of the Plan?

    _____

16. If the Plan is already in operation, has each employee-beneficiary received, and will each future employee-beneficiary receive, a written statement or schedule adequately and clearly stating all benefits allowable under the Plan, together with all applicable restrictions, limitations and exclusions, and the procedure for filing a claim for benefits?_____

17. If the Plan is not yet in operation, will each beneficiary receive a written statement or schedule as described in 16 above?

    _____

18. How often are the trust funds audited by an independent accountant?

    _____

    Name and address of auditing firm:_____

19. (a) Have all individuals that will handle receipts and disbursements for the Trust Fund been bonded under a fidelity bond issued by a surety authorized to transact such surety business in the State of Idaho?

    _____

    If so, give name and address of Surety_____

    _____

    and amount of fidelity coverage:_____

    (b) Are individuals handling receipts and disbursement for the Trust Fund licensed as per Idaho Code Chapter 9, Title 41?_____

20. Do you assert that this plan's program of coverage is qualified under the Employee Retirement Income Security Act (ERISA)?_____

    If so, attach a copy of notice of this qualification from the United States Department of Labor.

21. Please complete the attached chart on page 6.

	BENEFITS CHECKED ARE PROVIDED				CONTRIBUTIONS ARE MADE BY		APPROX. NUMBER BENEFICIARIES COVERED	
Benefit	Directly Out of Trust Fund	By Insurance Carrier(s)	By Hospital and Medical Serv. Plans	Other (Specify)	Employer	Employee Payroll Deduction	Employee	Covered Deps.
Disability Income								
Hospital								
Medical								
Surgical								
Dental								
Vision Services								
Other (Specify)								